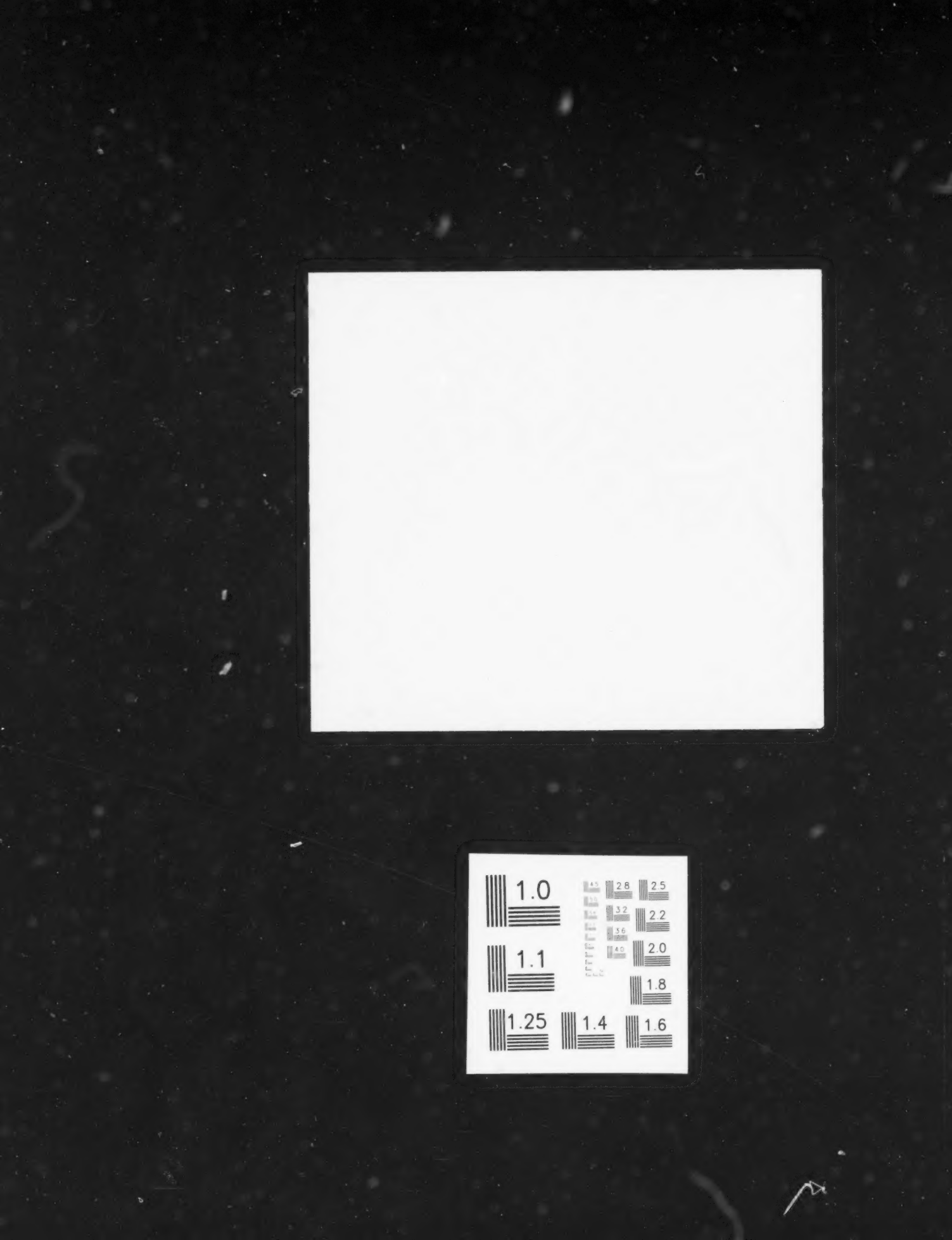
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Health Canada Santé Canada

Departmental Program Evaluation Division

Division de l'évaluation des programmes ministérielle

Applied Research and Analysis Directorate

Direction de la recherche appliquée et de l'analyse

Information, Analysis, and Connectivity Branch

Direction générale de l'information, de l'analyse et de la connectivité

CANADA PRENATAL NUTRITION PROGRAM

EVALUATION FRAMEWORK

November 1996

Canada

Our mission is to help the people of Canada maintain and improve their health.

Health Canada

Notre mission est d'aider les Canadiens et les Canadiennes à maintenir et à améliorer leur état de santé.

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The Departmental Program Evaluation Division provides objective information and advice on policy and program performance and works to strengthen departmental performance measurement and evaluation capacity in order to enhance the impact of Health Canada's activities on the health of the people of Canada.

La Division de l'évaluation des programmes ministérielle offre de l'information et des conseils objectifs sur le rendement des politiques et des programmes et s'efforce de renforcer la capacité du Ministère à mesurer et à évaluer le rendement afin d'accroître l'impact des activités de Santé Canada sur la santé de la population canadienne.

Canada Prenatal Nutrition Program
Evaluation Framework

Submitted to the
Evaluation Group
Strategic Planning and Evaluation Division
Strategic Planning and Review Directorate
Health Canada

March 29, 1996

(Revised November 1996)

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Executive Summary

This document outlines the proposed evaluation design for the Canada Prenatal Nutrition Program (CPNP), a $24.6 million program which was announced on July 26, 1994. The initial phase will run until March 31, 1998 and subsequently, the initiative will be supported on an on-going basis at $9.3 million annually.

The purpose of this Framework is to outline a evaluation design so that appropriate evaluation activities can be conducted in a timely manner. The evaluation findings obtained from the process outlined in this document will be used to assess the effectiveness of the program. The Framework provides the following:

1. Rationale for the CPNP, key characteristics of successful prenatal nutrition programs and the objectives of CPNP
2. Program implementation to date
3. The questions to be addressed in the evaluation
4. The data collection requirements
5. The evaluation design
6. Evaluation timelines and cost estimate

Because of the importance placed on collaboration and partnerships in this program, an integrated evaluation design has been proposed incorporating the Federal evaluation framework with other evaluation activities at the regional and local levels. With the development of an evaluation database for data collected at all levels, it is anticipated that useful evaluative information can be accessed in an efficient, timely and cost-effective manner as required during the implementation as well as at the end of the program.

104-00510/

List of Credits

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Chapter 1 The Canada Prenatal Nutrition Program

1.0 Rationale

On July 26, 1994, the Federal Government approved the Canada Prenatal Nutrition Program (CPNP), one of the programs promised in *Creating Opportunity* to support local community organizations to help at-risk pregnant women to deliver healthy babies in order to reduce the incidence of low birth weight. Based on population, the Program provides financial assistance to any province or territory that sets up or expands existing prenatal nutrition programs for expectant mothers who have low income.

Canada's low birth weight rate is higher than that of Norway, Finland, Sweden, France and Switzerland[1]. In 1990, 21,963 babies were born who weighed less than 2,500 grams at birth (or 5.4% of 405,474 live births); of these, 3,395 or 15% were very low birth weight (i.e., weighed less than 1,500 grams at birth). While the proportion of low birth weight babies declined sharply in the 1970's (a decrease in the magnitude of 25%), since 1980 the decline has been much less (a decrease of about 8%). In fact, in 1990 there were 900 more low birth weight babies born in Canada than in 1985 because of an increase in the total number of live births.

There are provincial and territorial differences in the proportions of babies born with low and very low birth weights. Low birth rates are proportionally higher in Quebec, Alberta, Nova Scotia, Ontario and Manitoba while very low birth rates are proportionally higher in the Northwest Territories, Nova Scotia, Manitoba, Alberta and British Columbia (no figures available for Newfoundland). Girls have a lower term birth weight than boys; their low birth weight rate is 17% higher than for boys. Prematurity and low birth weight for aboriginal babies is twice that of the Canadian population; for Inuit babies, the rates are four times higher. High birth weight rates are also a problem in these two groups.

Short gestation and low birth weight are major factors in death rates within the first 28 days of life; 41.2 babies per 100,000 die for this reason (third after birth defects and respiratory distress syndrome). For those low birth weight babies who survive, the lower the birth weight, the higher the need for care. Many of these babies face increased risks of neuro-development disabilities and chronic health problems throughout childhood. The health costs associated with caring for infants outside of the normal birth weight range are significant and need to be reduced. The initial costs associated with low birth weight have been estimated to

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[1] Background information in this section obtained from The Health of Canada's Children: A CICH Profile, second edition, Canadian Institute of Child Health. Ottawa: 1994.

be on the average of $60,000 per infant. In addition, some infants with low birth weight require on-going social, educational and health care services which can significantly increase societal costs.

Several factors contribute to low birth weight including poor maternal health and nutrition, maternal poverty and maternal smoking. More than 10% of babies born in Canada every year, or approximately 41,000 of 400,000 annual births, are at risk of having a low birth weight because of the poor health/nutritional status of their mothers. In research conducted at the Montreal Diet Dispensary, it was shown that for every dollar invested in comprehensive prenatal care for at-risk pregnant women, eight dollars can be save in neonatal care. In addition, babies born into poverty are at higher risk of low birth weight because of such maternal factors as poor housing, stress, abuse and unhealthy lifestyles. Another factor which has a strong and consistent impact on birth weight is maternal smoking. In 1990, 34% of women in their childbearing years (aged 20 to 44) reported that they currently smoked. For Native mothers, gestational diabetes, associated with high birth weight babies, is an additional health issue.

2.0 The Objectives of CPNP

CPNP is a broad, flexible health promotion program which assists communities in developing or improving programs for at-risk pregnant women in order to improve birth outcomes. It provides financial contributions for community-based projects to offer food supplementation, nutrition counselling, support, education, referral and counselling on such lifestyle issues such as alcohol abuse, stress and family violence. After birth, the projects can continue providing assistance until infants are six months of age. In particular, the program has the following objectives:

1. To reduce the incidence of babies born with unhealthy birth weights;

2. To improve the health of pregnant women;

3. To promote the initiation and duration of breastfeeding;

4. To increase the accessibility of services for:

   - Less adequately served high-density urban and isolated-rural Northern areas;
   - Culturally or linguistically hard-to-reach at-risk mothers and infants;

5. To increase partnerships, linkages and collaboration in the community in order to increase the recognition and support for the needs of at-risk mothers and

infants and to increase the number of effective community resources and programs for them.

3.0 Target Group

There are a number of target groups identified for assistance from the CPNP. These include pregnant women (including teens) living in poverty, or who drink or take drugs, live in violent situations, live in isolation or have poor access to services, are diagnosed with gestational diabetes, or who are either Status First Nations women living on or off reserves, Inuit or refugees.

4.0 Key Program Characteristics

The design of the Canada Prenatal Nutrition Program was based on the key characteristics of successful programs identified in several Health Canada reviews of the literature on prenatal nutrition programs (Choquette & Julien, 1995a, Choquette & Julien, 1995b, Winquist, 1995). The literature supported the conclusion that nutrition is a key factor in pregnancies resulting in low birth weight babies. In addition, the following characteristics were associated with successful prenatal nutrition program outcomes:

1. Comprehensive care has been consistently shown to provide better pregnancy outcomes in high-risk women

2. Nutritional supplementation is associated with better pregnancy outcomes for high-risk populations. Participation in prenatal nutrition programs seems to at least overcome such risk factors as smoking, low pregravid weight and under-nourishment.

3. Improved pregnancy outcomes have been associated with increased duration of prenatal services and a low provider-to-client ratio; 1:1 prenatal nutrition counselling is optimal.

4. Nutrition counselling integrated within comprehensive care programs has been associated with improved pregnancy outcomes for high-risk populations.

5. The integration of First Nations and Inuit cultural values, practices and beliefs around pregnancy and childbirth enhances prenatal services to this population.

5.0 Program Implementation

The implementation of CPNP is a mutual responsibility of Health Programs and Promotion Branch (HPPB) and Medical Services Branch (MSB). Within HPPB, CPNP is delivered through the existing Community Action Program for Children (CAPC) Joint Federal/ Provincial/Territorial Management Committees (JMC's). Funds for the CAPC program stream are allocated to the provinces and territories on the basis of ensuring that each jurisdiction has sufficient funds for at least one significant program ($150,000) plus an amount based on the percentage of births at risk (calculated at 10% of live births). In the territories, where program delivery and food are comparatively more expensive, funding is allocated on the basis of 100% of births being at risk. Contribution payments are made under the existing terms and conditions for CAPC.

MSB delivers the First Nations and Inuit Component of CPNP. Funding, based on population, is provided directly to Band Councils, Tribal Councils or Aboriginal Groups according to regional decisions through contribution agreements for the Brighter Futures Program.

The financing of the program is based on a combination of new funding and reallocations within Health Canada. The following table outlines original new grants and contributions allocated to the program and subsequent changes which have resulted from Program Review I.

CPNP Funding

Budget Year	HPPB		MSB
	Original Funding	After Program Review I	
1994 - 1995	$6.6M	$2.6M	$700K
1995 - 1996	$5.8M	$3.1M	$2.5M
1996 - 1997	$17.1M	$9.6M	$5.0M
1997 - 1998	$16.8M	$9.3M	$5.0M
Ongoing	$16.8M	$9.3M	$5.0M

Project selection criteria are provided in Appendix 1. Applications can be submitted by incorporated, not-for-profit community or voluntary organizations in partnership with public health units. HPPB shepherds would-be projects through the application phase, selects appropriate projects, develops contribution agreements, monitors project development and administers funds. In some regions, funds are being used to improve or expand existing

prenatal health programs. In areas where projects did not exist, resources have been provided to help to develop and deliver new projects, always in consultation with the provinces and territories. In this way, the Program will not duplicate or replace existing government services.

First Nations and Inuit communities vary in the degree of project implementation across the country. Several communities have projects in operation but many are in the planning stage. Additional First Nations activities will centre around supportive actions including training and development of culturally appropriate educational and promotional material.

Project components are selected from among the following:

1. Prenatal nutrition supplements (food, prenatal vitamins) recommended by a registered dietitian or doctor working with the project. Note that all projects must have a registered dietitian as part of the project planning team and work with on-going training of staff and delivery of the program. In remote areas, consultation may be done by telephone or community visits.

2. Dietary assessment and nutrition counselling on food acquisition and preparation and on good eating habits.

3. Promotion of breastfeeding, mother-baby bonding, healthy baby feeding and birth planning.

4. Participation of pregnant and new mothers in the planning and delivery and evaluation of the program.

5. Education on such things as food preparation, shopping on a budget, parenting and baby feeding.

6. Preparation for labour and delivery.

7. Support and counselling on lifestyle issues such as stress, tobacco use, alcohol and drug abuse and family violence.

8. Social supports including counselling, education, and other help from professionals, lay family workers or peers, through home visits, drop-in centres and group sessions.

9. Support for sufficient and nutritious food though community activities such as collective kitchens, community gardens and food-buying clubs.

10. Linking and referral to other resources, community programs or services.

Chapter 2 The Approach to the Overall Evaluation

1.0 Departmental Preparation for Evaluation

From 1994 to early 1996, HPPB was involved in a number of developmental activities in relation to evaluation planning. These are outlined below.

1. Literature Reviews

In early 1995, the HPPB and the Medical Services Branch (MSB) commissioned a series of literature reviews of prenatal nutrition program evaluations. These reviews provided a valuable research base for the development of the national evaluation framework by providing lists of risk profile variables and outcome indicators. (These literature reviews are available under separate cover.)

A study of Canadian prenatal programs with nutrition components served to reinforce and validate the variables identified in the literature.

2. Stakeholder Involvement

Because a community development approach has been taken to program management in CPNP, a number of stakeholder committees or working groups have been established to support its activities. These include:

a) CPNP National Evaluation Working Group

This group includes first line representatives from HPPB and MSB, Indian & Northern Health Services, Health Promotion Directorate, the Policy and Consultation Branch, Health Canada's Alberta Regional Office, and the Bureau of Biostatistics and Computer Applications; and community representatives from the Assembly of First Nations, Pauktuutik Inuit Women's Association, the Toronto Department of Public Health, and Manitoba Health. The group provides a broad perspective on evaluation issues as they relate to prenatal nutrition.

b) CPNP Regional Evaluation Working Group

This group includes representatives of the Health Canada Regional Offices as

well as representatives from HPPB and MSB. This committee provides a link to the Joint Management Committees at the regional level.

c) Health Canada Management Team

This group includes CPNP and MSB staff and two consulting nutritionists. This group provides consultation as appropriate on emerging evaluation issues.

d) Expert Group on Baseline Data Collection/Compilation

This group combines the expertise of a demographer, statistician, nutritionist-epidemiologist, program evaluator and other research and prenatal experts to collect information on prenatal risk factors and pregnancy outcomes in areas of Canada in which CPNP-type programs are not currently available. This study will determine rates of adverse pregnancy outcomes among at-risk women who are eligible for CPNP programs but have not yet had access to them. The information collected in this study will provide a backdrop for the CPNP evaluation and will allow more valid conclusions to be drawn about program outcomes and impacts.

e) Interactive Evaluation Workshops

During the Fall of 1995, four interactive workshops were conducted using a community development approach. Their purpose was to identify evaluation needs and challenges, to discuss and identify evaluation indicators to be collected at the national, provincial/territorial and local levels, and to refine evaluation questions and data to be collected. A total of 143 local and regional community representatives attended the two-day workshops which were held in Edmonton, Halifax, Saskatoon and Toronto.

The workshops provided HPPB staff with the opportunity to provide background to CPNP programs. A baby quilt was displayed as visual metaphor to explain how the various parts of the evaluation process fit together. Each square of the quilt represented an individual project at the local level with its own individual configuration; groups of squares represented regional groups of programs; and the binding around the squares represented the Federal evaluation framework within which all CPNP programs fit. Participants spent a good portion of the workshop time developing possible items for inclusion in local and/or regional evaluation tools. They brought a wealth of program experience to the table to ground evaluation activities in what would work in their various domains.

Feedback received about the interactive workshops was very positive overall. Each built on the preceding one and presentation format was modified from

iteration to iteration to better meet participants' needs. In particular, they appreciated:

1. The opportunity to participate in developing the evaluation questions as well as having input into the evaluation process

2. The opportunity to meet with and talk to workshop participants representing a variety of local projects and levels Health Canada staff

3. The appropriateness of the quilt metaphor as used to explain the overall evaluation process as it helped them see how their individual projects fit into the overall evaluation framework.

Based on the draft items which participants prepared, a draft list of indicators was developed to incorporate into evaluation tools.

These groups have put into practice the program's determinants of health approach by building partnerships and coalitions among community groups and the formal health and social service delivery systems. Together they have been able to solve problems in a collaborative fashion in relation to the planned evaluation.

2.0 Evaluation Challenges

The extensive consultation and collaboration process which characterized the developmental phase of the CPNP has resulted in a great deal of information which will be useful in guiding evaluation activities. A number of evaluation challenges identified by stakeholders are described below.

1. Evaluation Design Challenges

a) The variety of nutritional and dietary assessment tools selected by projects

b) The need to define *support* as a component of CPNP (suggestions included informational support, tangible help, emotional support and integrated support)

c) The need to define *success*, particularly in terms of how much change to birth weight constitutes project success

d) The need for baseline data for comparative purposes

e) The need to separate out CPNP-funded project outcomes when funding may be an add-on to an existing program

2. Contextual Challenges

a) The need to link evaluation activities between HPPB and MSB

b) The varying abilities of projects, in terms of staffing and technology, to support evaluation activities

c) The overlap in evaluation requirements among programs (e.g., CAPC and CPNP) and between levels of CPNP (i.e., local, regional, federal)

d) The need to build commitment to the evaluation on the part of project staff and clients

In conducting the evaluation activities described in this framework, these design and contextual challenges will have to be taken into account.

3.0 Levels of Evaluation

Health Canada will coordinate the evaluation of the CPNP. Several levels of evaluation will be conducted simultaneously, including:

1. National Evaluation

A global evaluation will focus on program relevance, overall success and cost effectiveness. This type of evaluation will utilize information from the general population; from partners/provinces, specific target groups and program providers with a focus on relevant outcomes. Indicators of the cost of neonatal care and other costs associated with the later medical and social interventions will be examined along with pertinent demographic and/or baseline data. This evaluation is described in this Framework document.

2. Impact Evaluation

The second level of national evaluation activities will be based on the results/impacts of the CPNP projects. It is hypothesized that there will be a positive correlation between food supplementation, support, education and counselling and healthy pregnancy outcomes for both mother and baby. The

national workshops held in the Fall of 1995 produced a list of field-based indicators which will combine to form a database of project-level impact information. A draft version of the impact evaluation indicators is provided in Appendix 3. The draft evaluation tools will be piloted in the Spring of 1996 in five projects selected from across Canada. They are located in Whitehorse, YK; Calgary, AB; Meadow Lake, SA; Toronto, ON; and Amherst, NS. Data provided by the pilot will be used to develop and test a CPNP database for local, regional and federal evaluation information. These tools are also being piloted in two First Nations and Inuit communities (Wapole Island and Baker Lake).

3. Other Evaluation Levels

The database developed for the CPNP can be manipulated to extract pertinent data in any number of combinations. It is anticipated that individual projects and regions will request specific evaluation data of use to them in an on-going manner.

Because of the extensive nature of the evaluation data likely to be available in this program, coordination of data collection activities is essential to reduce overlap.

Chapter 3 The Evaluation Framework

The evaluation framework presented in this chapter provides a template for data collection activities which will occur between April 1, 1996 and March 31, 1998. The extensive nature of the collaboration and coordination that has characterized the CPNP evaluation development activities to date have resulted in an efficient evaluation process which should significantly decrease duplication of effort and reduce costs. At the same time, the framework is flexible enough to incorporate additional research activities (e.g., case studies, population studies) as opportunities present themselves.

The evaluation questions are outlined below followed by a description of data collection methods. The evaluation framework is then presented followed by a suggested timeline and cost estimate.

1.0 The Evaluation Questions

The proposed evaluation questions are grouped under four broad priority areas for program evaluation. These include:

1. Relevance of the program
2. Implementation Process
3. Program success
4. Cost-effectiveness

Questions for each of these are outlined below.

1.1 Relevance of the Program

1. After four years of implementation, do the conditions that led to the creation of the CPNP still exist and justify the continuation of a program at the Federal level dedicated to the issue of prenatal nutrition?

2. Does the CPNP duplicate other Federal programs inside or outside Health Canada?

3. How and to what extent does the CPNP complement or expand upon other prenatal programs addressing the same issue at the provincial,

municipal and community levels?

4. Is the CPNP still the appropriate type of intervention? Should the federal government continue to be involved or could equally satisfactory results be delivered by another level of government and/or the private or voluntary sector?

1.2 Implementation Process

1. Has the CPNP reached the intended target groups (including First Nations and Inuit)? If not, why not?

2. What have the participation rates been?

3. Has the CPNP increased the accessibility of services for mothers and babies who are:

   a) Less adequately served physically (e.g., high density urban areas, isolated rural/northern areas)

   b) Less adequately served culturally

4. Were appropriate systems or mechanisms established to coordinate, monitor and evaluate Program activities?

5. What were the strengths and weaknesses of the approach used for Program implementation?

6. What evidence is there that the projects have developed partnerships and cooperative relationships with other organizations (public or private), groups or individuals within their community?

7. Did CPNP increase the support by the community regarding the needs, interests and rights of at-risk mothers and infants?

1.3 Program Success

1. What evidence is there that the projects supported by the CPNP have had the desired effect on pregnancy outcomes, including:

   a) Birth weight
   b) Infant health
   c) Maternal health
   d) Breastfeeding rates and duration

2. Which types of projects and project activities were more effective in improving pregnancy outcomes?

3. What lessons can be learned from these projects?

1.4 Cost-effectiveness

1. What would the costs have been without the CPNP?

2. Are there other cost-effective ways of delivering the local programs/projects?

2.0 Methods of Data Collection

The comprehensive evaluation design includes the following elements:

1. Baseline Data

If impact is to be attributed to the CPNP, it is important to be able to compare CPNP results with those of comparable communities without the CPNP intervention. While the baseline study is still in a developmental phase, it is hoped that a series of communities across Canada which have equivalent risk profiles will be studied for comparable indicators related to pregnancy outcomes.

2. Individual Project Questionnaire (IPQ)

The Individual Project Questionnaire (IPQ) has already been drafted and is currently being used in the five pilot communities. At the end of June, 1996 it will be revised based on feedback from the field and will then be completed by all CPNP projects on an annual basis. It will also be tested in two First Nations and Inuit communities. This information will be entered into the CPNP Database for analysis as required. General topics covered by the survey are described below.

Individual Project Questionnaire (IPQ) Topic Outline

1.0 Project Overview

Agency Type
Program Overlap
Project Characteristics:
- Location
- Target Population
- Project Staff
- Budget

2.0 Project Intervention

Type of Intervention
Client Participation:
- Program Completion/Cooperation
- Referral Utilization

3.0 Pregnancy Outcomes

Birth weight
Infant health
Maternal health
Breastfeeding

4.0 Project Outcomes

Spin-offs
Collaboration:
- Partnerships
- Sustainability/Community Ownership

Lessons Learned

3. Individual Client Questionnaire (ICQ)

As part of the cooperative nature of this evaluation, individual client data is being collected by projects according to their information needs and those of their regions. In a fashion similar to the IPQ, project data will be included in the CPNP Database. Individual project and regional reports will be generated as needed. At the same time, some client-based information will be useful for the national evaluation framework. General topics covered by the survey include:

Individual Client Questionnaire (ICQ) Topic Outline

1.0 Client Risk Profile

2.0 Client Utilization of Project Services

3.0 Maternal Outcomes

A list of the indicators on which information is going to be collected by the IPQ and by the ICQ is provided in Appendix I.

4. Document Review

As required, the minutes of Health Canada meetings regarding CPNP will be reviewed for issues related to coordination, monitoring and evaluation activities. In addition, some program files may be reviewed for additional information related to these topics.

5. Interviews, Senior Staff

Senior staff at HPPB and MSB may be interviewed to gain their perspective on Program implementation issues.

6. Stakeholder Focus Groups

Utilizing current stakeholder structures, a series of stakeholder focus groups will be held to assess strengths and weaknesses related to Program implementation.

7. Unobtrusive/Emergent Measures

In some cases, when researching one particular topic, information which instructs another topic may be discovered. By incorporating unobtrusive and emergent measures into the evaluation framework, the research process remains flexible and responsive to emerging program issues and needs.

8. Literature Review

Statistics Canada *Health Reports* and other pertinent epidemiological data which may become available during the evaluation period will be reviewed for global Canadian statistics related to low birth weight during the evaluation period.

9. Statistical Analysis

It is anticipated that statistical analysis, using the Statistical Package for the Social Sciences (SPSS) will be used to analyze data on the Program database. In particular, Cross-tabs and other descriptive statistical procedures will be employed.

10. Cost Effectiveness Analysis

Comparisons will be made between program outcome data and global Canadian statistics from a cost effectiveness perspective.

11. Case studies

If resources permit, a series of seven case studies (including one in a First Nations community and one in an Inuit community) will be conducted to capture the more qualitative aspects of program implementation, outcomes and lessons learned; to reflect the differing project responses to varying community needs; and to put a human face on research findings.

3.0 The Evaluation Framework

The following pages provide the Evaluation Framework and include evaluation objectives, evaluation questions, information sources and program indicators.

CANADA PRENATAL PROGRAM

Evaluation Framework

Evaluation Objectives	Evaluation Questions	Information Source	Program Indicators
1. PROGRAM RELEVANCE			
1.1 To determine the continued need for the CPNP at the Federal level.	**1. After four years of implementation, do the conditions that led to the creation of the CPNP still exist and justify the continuation of a program at the Federal level dedicated to the issue of prenatal nutrition?**	Statistics Canada Low Income data (including income data for aboriginal people) Canadian Perinatal Surveillance System (including aboriginal people) Surveys of Aboriginal people Statistics Canada, Health Reports	Birth weight rates (non CPNP) Infant health (non-CPNP) Maternal health (non-CPNP) Breastfeeding rates/ duration (non-CPNP) National rates Program overlap
	2. Does the CPNP duplicate other Federal programs inside or outside Health Canada?	IPQ and MSB project reports rollups	Program overlap
	3. How and to what extent does the CPNP complement or expand upon other prenatal programs addressing the same issue at the provincial, municipal and community levels?	IPQ and MSB project reports rollups	Sustainability/Community Ownership
	4. Is the CPNP still the appropriate type of intervention? Should the federal government continue to be involved or could equally satisfactory results be delivered by another level of government and/or the private or voluntary sector?	IPQ and MSB project reports rollups	

Evaluation Objectives	Evaluation Questions	Information Source	Program Indicators
2. IMPLEMENTATION PROCESS			
2.1 To determine if the CPNP reached its target groups	1. **Has the CPNP reached the intended target groups (including First Nations and Inuit)? If not, why not?**	IPQ and MSB project reports rollups	Target population
	2. **What have the participation rates been?**	IPQ and MSB project reports rollups	Target population Program completion/ cooperation
2.2 To determine if the CPNP increased accessibility of services	1. **Has the CPNP increased the accessibility of services for mothers and babies who are:**	IPQ and MSB project reports rollups	Target population
	a) **Less adequately served physically (e.g., high density urban areas, isolated rural/northern areas)**	IPQ, ICQ and MSB projects reports rollups	Target Population Client Utilization of Project Services
	b) **Less adequately served culturally**	IPQ, ICQ and MSB projects reports rollups	Target Population Client Utilization of Project Services
2.3 To determine if the CPNP provided appropriate program management	1. **Were appropriate systems or mechanisms established to coordinate, monitor and evaluate Program activities?**	Document Review Interviews, Senior Staff Stakeholder Focus Groups	Level of collaboration Incidence of crisis management Stakeholder satisfaction Evaluation products (quality, appropriateness)
	2. **What were the strengths and weaknesses of the approach used for Program implementation?**	Interviews, Senior Staff Stakeholder Focus Groups Unobtrusive/Emergent Measures	Emergent

Evaluation Objectives	Evaluation Questions	Information Source	Program Indicators
2.4 To determine the nature of partnerships which were developed by CPNP projects	**1. What evidence is there that the projects have developed partnerships and cooperative relationships with other organizations (public or private), groups or individuals within their community?**	IPQ and MSB projects reports rollups	Partnerships
	2. Did CPNP increase the support by the community regarding the needs, interests and rights of at-risk mothers and infants?	IPQ and MSB projects reports rollups	Spin-offs Collaboration
3.0 PROGRAM SUCCESS			
3.1 To determine the impact of the CPNP on pregnancy outcomes	**1. What evidence is there that the projects supported by the CPNP have had the desired effect on pregnancy outcomes, including:** **a) Birth weight** **b) Infant health** **c) Maternal health** **d) Breastfeeding**	Baseline Study MSB projects reports rollups IPQ ICQ ICQ IPQ	Birth weight rates in CPNP communities vs non CPNP communities Birth weight rates Infant outcomes Maternal outcomes Breastfeeding rates/duration
3.2 To determine the effectiveness of various types of CPNP projects and activities	**1. Which types of projects and project activities were more effective in improving pregnancy outcomes?**	IPQ/ICQ and MSB projects reports rollups	Statistical analysis: Project type by outcomes Project activity by outcomes
	2. What lessons can be learned from these projects?	Case studies IPQ Case studies	Emergent from site visits Anecdotal information Emergent from site visits

Evaluation Objectives	Evaluation Questions	Information Source	Program Indicators
4. COST EFFECTIVENESS			
4.1 To determine if the CPNP is cost effective.	**1. What would the costs have been without the CPNP?**	Literature review	Cost per LBW baby x # LBW babies in Canada (96-98)
	2. Are there other cost-effective ways of delivering the local programs/projects?	Baseline study IPQ	LBW comparisons (CPNP/ non-CPNP communities) Cost per client

4.0 Evaluation Timeline

An overview of evaluation activities over time is presented in the following chart.

TASK SCHEDULE

Data Collection Activities	1996-97				1997-98				1998-99			
	Ap - June	July - Sept	Oct - Dec	Jan - Mar	Ap - June	July - Sept	Oct - Dec	Jan - Mar	Ap - June	July - Sept	Oct - Dec	Jan - Mar
Baseline Data Collection												
IPQ/ICQ Survey Pilot												
Database Development												
IPQ/ICQ Survey Implementation												
Document Review												
Interview, Senior Staff												
Stakeholder Focus Groups												
Unobtrusive/Emergent Measures												
Literature Review												
Statistical Analysis												
Cost Effectiveness Analysis												
Case Studies (optional)												
Report Preparation												

5.0 Cost Estimate

It is estimated that the cost of conducting the evaluation will be $70,000 (1996 dollars) excluding the case study option. If this option is selected, each case study should cost an additional $7,500 plus travel costs. Because of the integrated nature of this evaluation design, a number of evaluation activities will occur outside of this budget, including the baseline study (costs supported by HPPB) and the maintenance of the IPQ/ICQ database (costs supported by individual programs accessing the database).

6.0 Project Update

As this Framework goes to press (November 1996), a number of program developments have occurred. The five pilot sites collected data successfully using the Individual Project Questionnaire (IPQ) and the Individual Client Questionnaire (ICQ) over a two- to three-month period. An in-person feedback session was held with program personnel on June 27, 1996 in Calgary to obtain feedback received was positive in terms of ease of use of the instruments. Many useful suggestions were provided about the wording of specific items and these were incorporated into the finalized versions of the instruments. In July, two additional pilot sites, Walpole Island and Baker Lake, were selected by Medical Services Branch to test the instruments in aboriginal and Inuit communities and these finalized tools were used in these sites.

The database for the pilot version of the instruments was finalized and reports were generated for the pilot sites. The database is now being upgraded to reflect final changes to the instruments. A series of regional workshops has been held across the country to train program personnel in the use of the instruments. Mandatory ICQ questions have been identified at the federal level, and the regions are currently determining if they require additional mandatory items. The local programs are being offered the option at the training workshops of selecting locally relevant questions for inclusion in their customized instruments which should be available for use by the beginning of 1987. A data collection schedule has been established and the first national evaluation report, describing IPQ data for 1996-1997, will be available in June 1997.

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Appendix 1

Guiding Principles of CPNP

A. Guiding Principles of CPNP

1. Mothers and Babies First

The health and well-being of the mother and baby are most important in planning, developing and carrying out every program.

2. Strengthening and Supporting Families

Families have the main responsibility for the care and development of their children. However, all parts of Canadian society, governments, agencies, employers, organized labour, educators and voluntary community organizations share the responsibility for children by supporting parents and families.

3. Equity and Accessibility

Program must meet the social, cultural and language needs of pregnant women in the community and must be available in all parts of the country, particularly isolated areas or those with poor access to services, to women with disabilities, to refugees, and to off-reserve Indian, Metis, aboriginal and Northern women.

4. Partnerships

Partnerships and cooperative activities at the community level are the key to developing effective programs. Programs must work in partnership with other services in the community.

5. Community-based

Decision making and action must be community-based. Pregnant women, new mothers, families and community groups must have an active role in planning, designing, operating and evaluating programs. New programs and changes to existing programs must be based on what the participants need and want, and be appropriate to the culture and language of the women.

6. Flexibility

Programs must be flexible to respond to the different needs in each community and to the changing needs and conditions of women in these communities.

the changing needs and conditions of women in these communities.

B. Guiding Principles: CPNP First Nations and Inuit Component

All Canada Prenatal Nutrition Programs will be designed around the principle of **mothers and infants first. The health of the mother and child must be the primary consideration in planning, developing, carrying out and evaluating every program.**

In addition, these principles of the Brighter Futures Initiative - First Nations and Inuit component should be used to guide your proposal development:

1. **Strengthening and supporting the Child/Family/Community through a holisticapproach.**

   While parents have the primary responsibility for the care and development of their children, the community shares this responsibility by supporting parents in their role. The goal is to attain community wellness by offering support such as education, health care, social and economic development of the community and its members.

2. **Community-Based**

   The community id the key to decision making and action for planning, designing, carrying out and evaluating their prenatal nutrition program. First Nations and Inuit must have the opportunity to develop appropriate programs to meet their cultural and community needs.

3. **Community wide participation**

   While the health of the mother and child is the primary consideration for prenatal programs, participation from all community members - women, men, elders, adolescents and children - in planning and delivering the program is encouraged.

4. **Community-Paced**

   Program development is to occur at a pace determined by each Firts Nations and Inuit community and within the parameters of fiscal and evaluation time-frames.

5. **Support and Follow-up (Continuing Care)**

   Support will coonsist of a range of programming that leaves no gaps and includes promotion, prevention, support, and follow-up care. While the focus of CPNP is the

health of pregnant women and their newborns, the support can be expanded through other existing programs to span the range from preconception health and education to programs dedicated to healthy babies, parenting skills and child development.

6. Coordination and linkage with other program activities

Programs that have the greatest impact are those with links to other community-based programs and activities. This may involve using CPNP to strengthen and enhance existing programs, and to ensure referral of participants to other community programs and resources. If cost-effective, pooling funds and sharing resources/personnel with other communities and/or off-reserve programs programs should also be considered.

Appendix 2

Selection Criteria for CPNP

A. Program Selection Criteria for CPNP

1. Promoting the health of pregnant women, new mothers and babies up to six months of age

2. Being based in communities where women are at highest risk, as identified through government and community consultations

3. Meeting identified community needs and not duplicating other services

4. Demonstrating strong community support and a coordinated, collaborative approach to the delivery of services to women

5. Being appropriate to the culture and language of participants

6. Focusing health promotion efforts on the whole family

7. Promoting community and professional partnerships by involving at-risk women, community groups and professionals (nutritionist, registered dieticians, community and social development workers, doctors, public health nurses)

8. Using many ways to find and involve at-risk pregnant women and new mothers as appropriate to the culture, language and special needs of those women

9. Planning for developing and sharing knowledge and expertise. evaluation criteria will be developed by Health Canada. Information on each project will be collected and distributed across the country.

10. Taking place in community-based locations such a public housing, community and neighbourhood centres, friendship centres, store fronts, schools, immigrant and refugee centres. Programs may need to be mobile to provide services in the home or workplace.

11. Being physically accessible to pregnant women, children and families with disabilities.

B. Program Selection Criteria for the First Nations and Inuit Component

To be eligible for funding, applicants must:

1. include a strong evaluation component in their program;

2. demonstrate strong community support and meet with existing and proposed community services;

3. demonstrate coordination and/or integration with existing and proposed community services;

4. enhance existing programs without duplicating services already available in the community;

5. include a planning and implementation process that includes the active participation of target groups and special interest populations such as women and seniors.

Appendix 3

Evaluation Indicators

CPNP EVALUATION INDICATORS
NATIONAL EVALUATION REQUIREMENTS

INDICATOR		INFORMATION SOURCE	
		(IPQ)	(ICQ)
1.0	**PROJECT OVERVIEW**		
1.1	Agency Type	✓	
1.2	Program Overlap	✓	
1.3	Project Characteristics:		
	.1 Location	✓	
	.2 Target Population	✓	
	.3 Project Staff	✓	
	.4 Budget	✓	
2.0	**PROJECT IMPLEMENTATION**		
2.1	***Type of Intervention***		
.1	Food Supplementation	✓	
.2	Nutrition Counselling	✓	
.3	Support	✓	
.4	Education Activities	✓	
.5	Lifestyle Counselling/ Referral	✓	
.6	Other	✓	
2.2	***Client Risk Profile***		
.1	Client Information		
	a) General Demographic		✓
	b) Client Weight Gain		✓
	c) Current Main Activity		
	d) Education Level		✓
	e) Income level		✓
.2	Previous Pregnancy History		✓

INDICATOR		INFORMATION SOURCE	
		(IPQ)	(ICQ)
.3	Present Pregnancy & Medical/ Health Issues		✓
.4	Dietary Assessment (Entry)		
.5	Attitude toward Breastfeeding		
.6	Risk Factors		
	a) Tobacco/ Substance Use		✓
	b) Alcohol/ Alcohol Substitute Use		✓
	c) Drug Use		✓
.7	Lifestyle Issues		
	a) Housing		
	b) Food Security		
	c) Abuse		✓
	d) Coping Skills		
	e) Self esteem		
	f) Support Network		
2.3	*Client Utilization of Project Services*		
.1	Program Completion/Cooperation	✓	✓
.2	Referral Utilization	✓	✓
.3	Length of Program Contact	✓	✓
.4	Use of Supplementation		
3.0	PREGNANCY OUTCOMES		
3.1	*Baby*		
.1	Birthweight	✓	✓
.2	Infant Health	✓	✓
.3	Morbidity/Mortality	✓	✓
.4	Baby's Home		

INDICATOR		INFORMATION SOURCE	
		(IPQ)	(ICQ)
3.2	*Mother*		
.1	Maternal Health		✓
.2	Dietary Change		
.3	Dietary Assessment (Exit)		
3.3	*Breastfeeding*		
.1	Breastfeeding Rates	✓	✓
.2	Breastfeeding Issues		
4.0	*PROJECT OUTCOMES*		
4.1	Spin-Offs	✓	
4.2	Partnerships	✓	
4.3	Sustainability/Community Ownership	✓	
4.4	Lessons Learned	✓	